MONDAY ALERT

New York State Alliance for Retired Americans

800 Troy Schenectady Rd., Latham, NY 12110 | 518-783-6231 | www.newyorkstateara.org

May 9, 2022

New York State's Minimum Wage Should Keep Up with the Needs of Workers With a Senior Perspective

Monday Alert/NYSARA note - *Six year's ago, right after NYSARA went from a 501c3 to a 501c4, NYSARA was very involved in a partnership of like minded organizations and people to raise the minimum wage. NYSARA was active in in person lobbying of legislators and the Governor to pass legislation that would raise NYS minimum wage to $15 per hour. Since our stated objective was to actively support and lobby on behalf of strictly senior issues many legislators were flummoxed about how minimum wages were a senior issue. We explained then and it continues to be true now that currently over 1/3 of those over 65 have to work to make ends meet, often in minimum wage jobs and the increased wages increase the contributions to the Medicare and Social Security trust funds. We joined others then in saying that NYS not only had to increase the minimum wage but had to be indexed to inflation guaranteeing that Minimum wage would keep pace with inflation and support families, unlike the current federal minimum wage. What we got six years ago was reason to celebrate but was a compromise that did not address all the important aspects or really solving the entire problem. While NYS is way ahead of many other States and the increase in minimum wage did not cause a financial armageddon, as our opponents predicted we need to do better. Now it is time to address the minimum wage challenge once and for all. NYS AFL-CIO President Mario Cillento writes the following op ed....*

New York State's minimum wage law has historically been inadequate for far too many workers. For decades, the minimum wage has been etched in statute as an inflexible and often arbitrary dollar amount that does not reflect the needs of working families. Making matters worse, the inflexible amount only changes AFTER the benefit has been stagnant for so long that its value has been rendered meaningless. The last such increase was in 2016, over 6 years ago, and was staggered at 3 different paces based on region. Each region's value is decreasing due to inflation and myriad other factors.

The minimum wage law continues to allow a separate and lower wage for tipped workers and there are several specific industries, such as fast food, that have had to resort to wage orders to keep pace with real-world worker needs. All of these factors combined have been a disservice to the workforce and contribute to broader pay rate problems. The stagnation of the minimum wage also contributes to stagnation of pay for incumbent, longer term workers as employers have no incentive or reason to ensure that their annual raises keep pace with entry level positions. Also, the ongoing staffing problems that continue to plague public and private sector employers are in large part a reflection of inadequate pay.

New York City and the suburbs are now at $15.00 an hour and upstate New York is at $13.20 an hour. Unfortunately moving forward, it appears the minimum wage will remain flat even as inflation is over 8%, and health care, energy, taxes, interest rates and other costs of living increase at a fast pace. It is time to address the shortfalls in our minimum wage law once and for all.

We need to index the minimum wage to address the true cost of living so that it increases at regular, sensible intervals. This will mean workers will be able to predict and rely on regular increases and it will remove the need to make the arbitrary and large increases to make up for past shortfalls. Indexation will also mean that businesses will be better able to budget and plan for the increases, rather than having to absorb a 'sticker shock' increase that we need to periodically enact.

An immediate catch-up should be enacted so that the cost of living in downstate areas is reflected. We should also ensure tipped workers are finally treated equally with all other workers. We urge the Legislature and Governor to enact these changes this session. We look forward to supporting this vital issue.

Medicare Pilot Program

ACO REACH

There has been a concern by some that a pilot program that potentially involves 100,000 Medicare participants would lead to all Medicare recipients being forced onto a Medicare Advantage program run by for profit entities that could destroy traditional Medicare. This program called the Direct Contracting Model under the Trump administration and allowed Medicare recipients to be changed to a Medicare Advantage program without their knowledge or permission has been renamed ACO REACH under the Biden/Harris administration and **absolutely does NOT allow the change.** Under direct contracting those monitoring the program were NOT representative of Medicare participants, consumers and family physicians while under ACO REACH those monitoring ARE representative.

Some organizations are making untrue statements that are "pants on fire" that attempt to seek donations to their organization. Those organizations have put out a letter about this "demonstration/pilot program that are blatantly untrue. In a future Monday Alert we will have the letter and will highlight the untrue statements in the letter. In the mean time educate yourself about this program both by reading the write up below and going to the web site to see the comparison of the Trump era program vs. the Biden era replacement that starts in 2023. See also the stated purpose of the program that is highlighted.

The Center for Medicare and Medicaid Innovation (Innovation Center) is releasing a Request for Applications (RFA) to solicit a cohort of participants for the Accountable Care Organization Realizing Equity, Access, and Community Health (ACO REACH) Model. The Centers for Medicare & Medicaid Services (CMS) has redesigned the Global and Professional Direct Contracting Model (GPDC) Model in response to Administration priorities, including our commitment to advancing health equity, stakeholder feedback, and participant experience. CMS is renaming the model the ACO REACH Model to better align the name with the **purpose of the model: to improve the quality of care for people with Medicare through better care coordination, reaching and connecting health care providers and beneficiaries, including those beneficiaries who are underserved, a priority of the Biden-Harris Administration.**

The new cohort will begin participation in the ACO REACH Model on **January 1, 2023**. Current GPDC Model participants must maintain a strong compliance record and agree to meet all the ACO REACH Model requirements by January 1, 2023 to continue participating in the ACO REACH Model as ACOs.

The redesigned ACO REACH Model reflects the priorities of the Biden-Harris Administration and responds to feedback from stakeholders and participants. ACO REACH will enable CMS to test an ACO model that can inform the Medicare Shared Savings Program and future models by making important changes to the GPDC Model in three areas:

1. Advance Health Equity to Bring the Benefits of Accountable Care to Underserved Communities. The ACO REACH model promotes health equity and focuses on bringing the benefits of accountable care to Medicare beneficiaries in underserved communities. ACO REACH will test an innovative payment approach to better support care delivery and coordination for patients in underserved communities and will require that all model participants develop and implement a robust health equity plan to identify underserved communities and implement initiatives to measurably reduce health disparities within their beneficiary populations.

2. Promote Provider Leadership and Governance. The ACO REACH Model includes policies to ensure doctors and other health care providers continue to play a primary role in accountable care. At least 75% control of each ACO's governing body generally must be held by participating providers or their designated representatives, compared to 25% during the first two Performance Years of the GPDC Model. In addition, the ACO REACH Model goes beyond prior ACO initiatives by requiring at least two beneficiary advocates on the governing board (at least one Medicare beneficiary and at least one consumer advocate), both of whom must hold voting rights.

3. Protect Beneficiaries and the Model with More Participant Vetting, Monitoring and Greater Transparency. CMS will ask for additional information on applicants' ownership, leadership, and governing board to gain better visibility into ownership interests and affiliations to ensure participants' interests align with CMS's vision. We will employ increased up-front screening of applicants, robust monitoring of participants, and greater transparency into the model's progress during implementation, even before final evaluation results, and will share more information on the participants and their work to improve care. Last, CMS will also explore stronger protections against inappropriate coding and risk score growth.

Compare the GPDC (Trump era program) to the ACO REACH (2023 Biden Administration program) at https://innovation.cms.gov/media/document/gpdc-aco-reach-comparison

Drug Prices Remain High and Unpredictable as Beneficiaries Look to Lawmakers for a Fix

From our Friends at Medicare Rights

Medicare drug prices keep rising faster than inflation, and 8 in 10 adults say the cost of prescription drugs is unreasonable. A recent *Health Affairs* article examines how and why Medicare Part D net prices are "significantly higher and growing much more rapidly than those paid by other payers, such as Medicaid. . . ".

The article references two Congressional Budget Office publications that found that Part D brand name costs are high relative to other federal payers and have grown much faster than inflation. The reports find that "market-wide assessments of net price growth hide significant variation" across payers. When considering both the net price growth and the change over time in the mix of drugs taken by people with Medicare, brand name drug costs grew more than

five times the rate of inflation from 2009 to 2018. They argue that this increase "is largely driven by use of high-price specialty drugs, which are a growing share of the drug pipeline," and that comprehensive reform is needed to avoid increasing burdens on Medicare, taxpayers, and beneficiaries because most of the expected gains from lower-cost generics have been realized.
Earlier this year, Medicare Rights flagged an AARP Public Policy Institute analysis that found drug companies increased list prices for 75 of the 100 brand name drugs with the highest Medicare Part D spending within the first two months of 2022. These increases mean that copayments or coinsurances that people expected when choosing their Part D plan during open enrollment may have also increased. Plans may change coinsurance and copay amounts when manufacturers change prices because copay amounts are set based on the full cost of the medication. These adjustments and increases can result in surprise increases in costs at the pharmacy counter.
These reports make it even more apparent that we must take immediate action to reform drug pricing. We support comprehensive efforts to lower prescription drug prices through capping beneficiary out-of-pocket (OOP) drug costs; realigning Part D financial obligations; penalizing drug manufacturers for price hikes that outpace inflation; and allowing Medicare to negotiate drug prices.

White House Issues "Older Americans Month" Proclamation

The White House has officially proclaimed the month of May "Older Americans Month," outlining a number of programs and resources that will help seniors remain safe and healthy as they age.

President Biden noted that the American Rescue Plan, passed into law in 2021, invested $1.4 billion to provide older adults with services for nutrition, health promotion, disease prevention, caregiver support, and long-term care. It also provided additional Medicaid funding to support millions of older adults with disabilities and to help states improve the quality of caregiving jobs.

"Older Americans contribute their time and wisdom to make our communities stronger, more informed, and better connected," said Biden in

the proclamation. “They are our loved ones, friends, mentors, essential workers, volunteers, and neighbors.”

In addition, the proclamation stated that the Administration is dedicated to improving the safety and quality of care in nursing homes — ensuring that facilities have sufficient staff, that families have the necessary information to support their loved ones, and that poorly performing nursing homes are held accountable.

“This White House is truly committed to providing the resources that seniors need to have a secure and healthy retirement,” said **Richard Fiesta**, Executive Director of the Alliance. “President Biden is a strong ally and Alliance members are determined to work with him to expand Social Security and lower drug prices.”

Alliance Facilitates Partnership with Labor Movement, SUNY to Help Students with Family, Financial Obligations

Building on a mentorship program that the International Association of Machinists and Aerospace Workers (IAMAW) established with Aviation High School in Long Island City, New York, the Alliance has helped bring together the American Federation of Teachers (AFT), the United Federation of Teachers (UFT) and IAMAW in a partnership with the State University of New York (SUNY) that provides pre-enrollment credits toward a college degree for high school students. The credits are for extra classes taken in a high school aviation program.

The partnership will credit graduates from Aviation High School who earn their Federal Aviation Administration airframe or powerplant license with 28 to 29 college credits — roughly the equivalent of one year of college — toward a bachelor’s degree in transportation management or labor studies before they enroll in courses at SUNY Empire State College.

President Roach spoke with the students in New York on Wednesday, April 27.

IAMAW officials have been working on the program with Aviation High School for two decades, and the Alliance facilitated discussions between AFT, UFT and SUNY officials to set a goal and execute a plan. The work culminated in Aviation High School and SUNY Empire State College representatives formally
signing the new agreement on April 27.

“The Alliance is engaging with young people as well as seniors. The program helps students who have to take care of parents, grandparents or other family members during high school, so they are not left behind due to their caregiving responsibilities. It also helps students who have financial or other family obligations and may need to work,” said **Robert Roach, Jr.**, President of the Alliance. “UFT members, who are affiliated with AFT, were key to obtaining this agreement. Their dedication and expertise led to this successful outcome. This is a program that could go nationwide if the results are what we believe we can achieve.”

Left to right: Janella Hinds, VP, Academic High Schools, U
Vaccaro, VP for Education, UFT; Steven Jackson, Principa
High School; Dora Cervantes, IAMAW Treasurer; President
Epstein, Exec. Dir., Office of Partnerships, SUNY Empire St
(ESC); Nathan Gonyea, Officer in Charge, SUNY ESC; Maria
Dean, Harry Van Arsdale Jr. School of Labor Studies, SU

More photos from the signing event can be viewed here. Visit the SUNY Empire State College website to learn more about this new and exciting program.

COVID-19 Death Toll Among Older Americans Still Rising

Throughout the coronavirus pandemic, unvaccinated people have accounted for a majority of COVID-19 deaths in the United States. But, in recent months, an alarming number of vaccinated older and disabled Americans have succumbed to the disease.

Forty-two percent of the people who died in January and February during the highly contagious omicron variant's surge were vaccinated, compared with 23% in September, the peak of the delta wave. Most of the vaccinated people who died had not received a booster shot. This analysis was conducted by *The Washington Post* using data from the Centers for Disease Control and Prevention (CDC).

While a majority of seniors are immunized, the vaccine's potency wanes over time, leaving older people vulnerable to severe infection. The highest concentration of vaccinated deaths occurred among older Americans and the immunocompromised, with those over the age of 75 making up two-thirds of the deaths from the 'omicron' wave.

Still, unvaccinated people remain far more likely to die from COVID-19 than the vaccinated, especially when compared to Americans who have received booster shots.

Health experts continue to stress that the overwhelming majority of the vaccinated will survive COVID-19 infection. However, they argue that the deaths serve as a reminder that high-risk groups such as older Americans should receive booster doses and exercise extra precautions during infection surges.

"Seniors remain especially vulnerable during this pandemic," said **Joseph Peters, Jr.**, Secretary-Treasurer of the Alliance. "The CDC has approved second booster doses for those 65 and older and those 50 and older with underlying medical conditions that increase their risk for severe disease

from COVID-19, and we encourage all seniors to follow their guidance when it comes to receiving that added level of protection."

***Kaiser Health News*: Medicare Surprise – Drug Plan Prices Touted During Open Enrollment Can Rise Within a Month**

By Susan Jaffe

Something strange happened between the time **Linda Griffith** signed up for a new Medicare prescription drug plan during last fall's enrollment period and when she tried to fill her first prescription in January.

She picked a Humana drug plan for its low prices, with help from her longtime insurance agent and Medicare's Plan Finder, an online pricing tool for comparing a dizzying array of options. But instead of the $70.09 she expected to pay for her dextroamphetamine, used to treat attention-deficit/hyperactivity disorder, her pharmacist told her she owed $275.90.

"I didn't pick it up because I thought something was wrong," said Griffith, 73, a retired construction company accountant who lives in the Northern California town of Weaverville.

"To me, when you purchase a plan, you have an implied contract," she said. "I say I will pay the premium on time for this plan. And they're going to make sure I get the drug for a certain amount."

But it often doesn't work that way. As early as three weeks after Medicare's drug plan enrollment period ends on Dec. 7, insurance plans can change what they charge members for drugs — and they can do it repeatedly. Griffith's prescription out-of-pocket cost has varied each month, and through March, she has already paid $433 more than she expected to.